Supplemental Nutrition Program for Women, Infants and Children
Montana Application for Operation of Satellite or Outlying Clinic

I. Instructions

A. It is suggested the applicant contact the State Program Coordinator before completing this application. Early contact between the applicant and the State Agency will help minimize problems.

B. Please answer all questions completely.

C. Use the most current data available.

The following factors will be taken into consideration, but not limited to, availability of funds, caseload, physical location, days of operation, and available equipment or funds to purchase additional equipment.

II. Applicant Information

A. Applicant Agency Name: _____

B. Address: _____

_____

_____

C. Telephone: _____

III. Proposed Service Area Statistics

A. Proposed Service Area: _____

B. Describe below the reasons for opening a clinic in the proposed service area and what benefits you anticipate. Provide any information you used in this determination; ie, reports, survey for interest, etc (use additional sheets if needed).

C. What is the service area population? _____

D. What is the service area racial/ethnic composition?

1. White _____%

2. Black _____%

3. Hispanic _____%

4. American Indian _____%

5. Asian or Pacific Islander _____%

E. What is the median family income in the service area ?_____

F. What is the incidence of the following for the service area:

1. Premature Infants:

2. Low Birth Weight Infants:

3. Teen Pregnancy:

4. Other risks you have identified (describe):_____

_____

_____

_____

G. Which of the following programs are available in the proposed service area. Provide the most current caseload figure. List contact person who is used for referral for each program.

1. Pathways/FAIM:

2. Special Nutrition Assistance Program (SNAP):

3. Medicaid:

4. MCH Home Visiting:

H. What is the anticipated caseload for the proposed service area?

1. Women

2. Infants

3. Children

I. List the name and location of the nearest authorized retailer(s) in the proposed area.

IV. Physical Location

A. Describe the location where participants will be served. Be specific (i.e. Health Department, City-County Building, Hospital, etc.). Describe office space, size of space, location of phone and power outlets, available waiting area, etc. A drawing of the space is helpful.

B. Describe what secure storage is available for food instruments, computer equipment, participant files, etc.

V. Nutrition Services

A. Provide the name of the individual who will act as Competent Professional Authority, CPA. Is this person currently a member of your staff, or will she/he be a new hire? If a new hire, provide qualifications (education, licensure, etc.) of the person.

B. Will it be necessary to hire other additional staff to provide WIC services in the proposed service area? Describe.

C. What is the planned staffing time -- CPA and Aide hours?

VI. Computer Requirements

A. Describe computer requirements you feel will be necessary to efficiently operate the proposed site. Will you be able to use existing equipment? Will upload/download processes be performed at the proposed site or at your main clinic? (Use additional sheets if needed.)

VII. Financial Management

A. Will the operation of the proposed clinic affect your current budget? Examples which could impact your budget include, salaries for additional staff, rent, utilities, supplies, weighing and measuring devises, etc. Describe in detail which you feel may have an impact, include an estimated cost (use additional sheets if needed).

B. As a consideration for satellite site applications, you must be prepared to enter into agreement with the county in which the site exists, if different than your main clinic. See definitions of satellite and outlying clinic sites, and the model satellite agreement in the State Plan.

VIII. Begin Date

A. When do you anticipate being ready to open a WIC clinic at the proposed site?

B. How many days per month and hours per day do you anticipate offering WIC services at this site?

The applicant agrees that WIC Program benefits will be provided to eligible participants without discrimination on the basis of race, color, national origin, age, disability or sex.

The applicant further agrees and assures that if this application is approved, it will comply with the WIC Program Federal Regulations and State Policies and Procedures for WIC Program operations.

The information contained in this application for a WIC Program is true and accurate to the best of my knowledge.

_____ _____

Date Signature of Local Official with Authority Implement WIC Program